STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 00 B. WING	11/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALPARAISO CARE AND REHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383

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F0000	This visit was for the Investigation of Complaint IN00112997 and Complaint IN00114283. Complaint IN00112997-Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F514 Complaint IN00114283-Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F314. Unrelated deficiency cited. Survey dates: November 25-28, 2012 Facility number: 000083 Provider number: 155166 AIM number: 100289670 Survey team: Janet Adams, RN Census bed type: SNF/NF: 146 Total: 146 Census payor type: Medicare: 20 Medicaid: 114 Other: 12	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post survey desk review on or after December 28, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 146 Sample: 14 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on December 2, 2012 by Bev Faulkner, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the Physician of a change in wound drainage for 1 of 4 residents reviewed for wounds in the sample of 14.(Resident #D). The facility	F0157	**F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal	12/28/2012

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	also failed to ensure timely attempts were made to notify the family of a resident's death for 1 of 3 discharged residents reviewed in the sample of 14. (Resident #G) Findings include: 1. The closed record for Resident #G was reviewed on 11/26/12 at 11:30 a.m. The resident's diagnoses included, but were not limited to, renal failure, adult failure to thrive, esophageal reflux, and high blood pressure. The resident was admitted to the facility on 4/7/12 and discharged to the hospital on 5/9/12. The resident was re-admitted to the facility on 5/16/12 from an inpatient Hospice facility. The resident expired at the facility on 5/19/12. Review of the resident's Admission information face sheet indicated there was no Funeral Home listed. One of the resident's daughters was listed as a contact /POA (Power of Attorney) for the resident. The 5/2012 Nurses' Notes were reviewed. An entry made on 5/19/12 at 3:58 a.m., indicated the resident's respirations had ceased at 3:25 a.m., and an order was obtained to release the body to the funeral home. The resident's daughter (the		representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident G's family was notified of her passing.	

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	daughter whose name was on the face sheet) was called and a message was left to return the call. The entry also indicated Hospice was notified. The next entry in the Nurses' Notes was made on 5/19/12 at 6:56 a.m. This entry indicated the family member's phone number was obtained from Hospice and (names of two female family members) were notified and several messages were left for the daughter who was listed on the face sheet and staff were going to continue to contact her. The next entry in the Nurses' Notes was made on 5/19/12 at 9:02 a.m. This entry indicated the resident's body was released to the funeral home. When interviewed on 11/28/12 at 8:35 a.m., the Director of Nursing indicated there was only one daughter listed on the admission chart. The Director of Nursing indicated she did not recall Hospice coming to the facility upon the resident's death. The Director of Nursing indicated there was a delay in notifying the resident's family. The Director of Nursing indicated it did not appear that staff made other contacts with Hospice prior to attempt to obtain phone number of other family members until 6:56 a.m.		· Resident D no longer resides at the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be affected by the alleged deficient practice. · The information on the resident face sheets will be reviewed/verified with the resident's responsibility party. · Upon admission/re-admission the IDT will review the resident's face sheet during clinical meeting to ensure pertinent information is available. · IDT will review the information on the resident's face sheet during care plan meetings and update as needed. · Charts were audited for residents with wounds to ensure that physician notification occurred for residents with a change of condition. · Nursing Management team completed skin assessments on all residents residing at the facility. **What measures will be put into place or what systemic changes you will make to** ensure that the deficient practice does not recur	

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	2. The closed record for Resident #D was reviewed on 11/26/12 at 12:40 p.m. The resident's diagnoses included, but were not limited to, renal failure, sleep apnea, peripheral vascular disease, diabetes mellitus, and congestive heart failure. The resident was admitted to the facility in 7/2012. The resident was sent to the hospital Emergency Room on 8/9/12 and was admitted to the hospital. The resident was re admitted to the facility on 8/22/12 from the hospital. The 8/2012 Nurses' Notes were reviewed. An entry made on 8/6/12 at 5:42 a.m., indicated the resident was afebrile (not having a fever). An entry made on 8/6/12 at 3:29 p.m., indicated the resident's treatment to the coccyx continued as ordered and the resident had no signs or symptoms of infection. The entry also indicated the resident was afebrile. An entry made on 8/6/12 at 7:39 p.m., indicated the treatment continued to the resident's coccyx and the resident's temperature was 98.2 (normal). An entry made on 8/7/12 at 6:01 a.m., indicated the resident's wound had a foul odor and a large amount of sanguineous(red drainage appearing thin and watery) drainage was observed. The next entry was made on 8/7/12 at 2:45 p.m. This entry indicated the the wound vac was in place and a large amount of serosanguineous (then		· Nursing staff will be educated on Physician/Family Notification by the SDC/designee by 12/28/12. · Nursing staff will be educated on the Hot Charting and Resident Change of Condition policy by the SDC/designee by 12/28/12. · Noncompliance with facility policy and procedure may result in employee re-education and/or disciplinary action up to and including termination. · The 24 Hour Report sheets are audited by the Unit Managers and/or designee to ensure resident change of condition is reported to the physician and family daily. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · The Unit Managers will complete a “Change of Condition” and “24 Hour Condition Report” CQI tool daily x 4 weeks, weekly x 8 weeks and monthly ongoing thereafter for at least 6 months to monitor family and physician notification compliance. · Social Services will complete a “Care Plan Updating” CQI tool weekly x 4 weeks and monthly ongoing thereafter for at least 6 months. · The “Care Plan Checklist” will be utilized during care plan	

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	and watery drainage that appears pink due to blood cells mixing in it) drainage was noted and the odor remained. An entry made on 8/9/12 at 4:30 p.m., indicated the resident's family reported the resident had complaints of chest pain and the resident was noted to be mumbling words, moaning, and her skin was hot to touch. The resident's temperature was 102.2 at this time. An entry made on 8/9/12 at 4:40 p.m., indicated the resident was transported to the hospital. An entry made on 8/10/12 at 8:16 a.m., indicated the resident was admitted to the hospital. The facility policy titled "Resident Change of Condition" was reviewed on 11/26/12 at 8:20 a.m. The policy was received from the Director of Nursing who indicated the policy was current. The policy was dated 8/98 and last revised on 3/10. The policy indicated the Nurse in charge was to notify the Physician prior to the end of the shift when a significant change in the resident's condition was noted. When interviewed on 11/28/12 at 8:35 a.m., the Director of Nursing indicated there was no documentation of the Physician being notified of the increased drainage and the odor of the drainage on 8/6/12 and 8/7/12.		reviews ongoing. This review includes all the information on the resident face sheet and will be updated as indicated by the IDT. · The CQI committee reviews the audits and action plans are developed if 95% compliance is not achieved to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action.	

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	This federal tag relates to Complaint IN00112997 and Complaint IN00114283. 3.1-5(a)(2) 3.1-5(a)(3)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure dependent residents who were at risk for developing or had pressure ulcers were turned and repositioned and pressure relieving devices were in place for 3 of 4 residents reviewed for pressure ulcers in the sample of 14. (Residents #K, #M, and #N) Findings include: 1. During orientation tour on 11/25/12 at 6:10 p.m., Resident #K was observed in bed. The resident was lying on his back and the head of the bed was elevated. The resident had a tracheostomy (a tube inserted into a surgical opening in the neck to maintain an airway) tube in place. The tube was connected to a ventilator (machine to supply oxygen to facilitate the resident's breathing).	F0314	**F314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident K, N and M's care plan and resident care sheet have been reviewed/updated as indicated and will be followed. Skin Assessment was completed on all three residents and no new	12/28/2012

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	On 11/26/12 at 8:00 a.m., the resident was observed in bed. The resident was awake and lying on his back. There were no pillows on either side of the resident. There were no staff members in the room. On 11/26/12 at 9:20 a.m. and 10:15 a.m., the resident was observed sitting in a wheelchair in the hall. There was no pressure relieving cushion or pad on the seat to the wheelchair. On 11/26/12 at 11:00 a.m., LPN #1, CNA #1, and CNA #2 were observed using a Hoyer lift (mechanical devise to transfer residents into a bed or a wheelchair) to transfer the resident from the wheelchair into his bed. When the resident was lifted out of the wheelchair there was no cushion or pressure relieving pad on the seat of the wheelchair. The resident was then turned to his side to remove the sling used with the Hoyer lift. There was a dressing in place to the resident's coccyx area. The LPN removed the dressing as the resident had been incontinent of stool. There was a pressure ulcer noted to the resident's coccyx area. The wound measured approximately 1 cm (centimeter) x 2 cm with a pale reddish/yellow center. On 11/26/12 at 11:55 a.m., the resident was observed in bed. The resident was		skin conditions were identified. · Resident K is being turned every two hours and is using a pressure-relieving cushion in the wheelchair. · Resident N is being turned every two hours. · Resident M is being turned every two hours and has a pressure-relieving device in the broad chair. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · Nursing Management team completed skin assessments on all residents residing at the facility. · Rounds are completed each shift by the charge nurse every two hours daily and by Customer Care Representatives to monitor resident care. Concerns are addressed with the resident's charge nurse. · Licensed nurses will be re-educated on following physician orders and plan of care by the DNS/designee by 12/28/12. · All staff will be inserviced on pressure reducing/redistribution devices by	

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	lying on his back with no pillows to either side of him. The resident was not receiving care from any staff member at this time. On 11/26/12 at 1:05 p.m., 3:00 p.m., and 4:30 p.m., the resident was observed in bed. The resident was lying on his back with no pillows to either side of him. The resident was not receiving care from any staff member at the above times. On 11/27/12 at 10:30 a.m., and 11:10 a.m., the resident was lying on his back with no pillows to either side of him. The resident was not receiving care from any staff member at these above times. On 11/27/12 at 11:52 a.m., two Occupational Therapy (OT) staff members were observed transferring the resident from his bed into the wheelchair. One OT staff member placed a folded white bed sheet on the seat of the wheelchair. There was no cushion or pressure relieving device in place on the seat of the wheelchair when he was transferred into the wheelchair. On 11/27/12 at 12:40 p.m. and 1:00 p.m., the resident was observed sitting in the wheelchair in his room. There was no cushion noted on the seat of the chair.		the SDC/designee by 12/28/12. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · The Director of Nursing Services is responsible to monitor for facility compliance. · Skin assessments are conducted twice weekly during shower/bed bath by a charge nurse to identify any skin concerns. · Unit Managers monitor resident care by making rounds on their units. Concerns are addressed with the nursing staff as needed. · Rounds are completed each shift by the charge nurse every two hours daily and by Customer Care Representatives to monitor resident care. Concerns are addressed with the resident's charge nurse. · Observations will be documented on the "Nursing Rounds Checklist" ongoing. The DNS/designee reviews the "Nursing Rounds Checklists" daily Monday – Friday. The Weekend Nursing Manager checks them on Saturday and Sunday for compliance. · Licensed nurses will be re-educated on following physician orders and plan of care by the DNS/designee by 12/28/12.	

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	On 11/27/12 at 1:05 p.m., two OT staff members were observed transferring the resident from the wheelchair into his bed. The white sheet was present on the seat of the chair. There was no cushion or pressure relieving device observed on the seat of the chair. The record for Resident #K was reviewed on 11/26/12 at 11:00 a.m. The resident was admitted to the facility on 11/16/12. The resident's diagnoses included, but were not limited to, tracheostomy, high blood pressure, acute respiratory failure, and malnutrition. Review of the 11/20/12 Pressure Wound Skin Evaluation Report indicated the resident had an unstageable pressure wound to the coccyx. The measurements were recorded as 2.0 cm x 1.9 cm. Review of the 11/16/12 admission Pressure Sore Risk Assessment indicated the resident was at risk for pressure ulcers related to decreased mobility and a history of pressure ulcers. Review of the 11/16/12 admission Physician orders indicated there was an order to cleanse the coccyx wound with normal saline, apply Santyl (a medicated ointment to debride a wound) and a fluffed gauze and cover the area daily and as needed.		· All staff will be inserviced on pressure reducing/redistribution devices by the SDC/designee by 12/28/12. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · Nurses will document observations on the "Nursing Rounds Checklist" each shift ongoing. The DNS/designee reviews the "Nursing Rounds Checklists" daily Monday – Friday. The Weekend Nursing Manager checks them on Saturday and Sunday for compliance. · The Customer Care Representatives will complete the "Accommodation of Needs" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter no less than 6 months. · Data will be submitted to the CQI Committee for review and follow up. If a 95% compliance is not achieved an action plan will be developed. · Noncompliance with facility procedures may result in disciplinary action.	

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	Review of the resident's temporary admission care plans indicated there was a care plan that noted the resident had impaired skin integrity. The temporary care plan was initiated on 11/16/12. Care plan interventions included for staff to turn and reposition the resident every 2 hours and as needed. Another intervention indicated a pressure reducing/relieving/redistribution device to the chair was to be utilized. When interviewed on 11/28/12 at 9:35 a.m., the Director of Nursing indicated the resident was to be turned and repositioned and a pressure relieving pad should have been in place as per the resident's plan of care. 2. During orientation tour on 11/25/12 at 6:00 p.m., Resident #N was observed in bed. The resident's eyes were closed and she did not respond when staff entered the room. The resident was lying on her back and her head was turned to the left side. The resident's arms were lying straight and flat on each side of her. There were pillows under each of the resident's arms and hands. There were no other pillows to either side of the bed. The resident was not receiving care from staff at this time. The head of the resident's bed was elevated. The resident had a			

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VALPARAISO CARE AND REHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383

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	tracheostomy tube in place and the tube was connected to a ventilator at the bedside. On 11/26/12 at 8:10 a.m., the resident was observed in bed with her eyes closed. The resident was on her back and the pillows remained under each of her arms. There were no other pillows on either side of the bed. The resident's eyes were closed. The resident was not receiving care from staff at this time. On 11/26/12 at 9:10 a.m., the resident was observed in bed with her eyes closed. The resident was on her back and pillows remained under each of her arms. There were no other pillows on either side of the bed. The resident's eyes were closed. The resident was not receiving care from staff at this time. On 11/26/12 at 10:15 a.m., the resident was observed in bed with her eyes closed. The resident was on her back and the pillows remained under each of her arms. There were no other pillows on either side of the bed. The resident's eyes were closed. The resident was not receiving care from staff at this time. On 11/26/12 at 11:10 a.m., the resident was observed in bed with her eyes closed. The resident was on her back and the			

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	pillows remained under each of her arms. There were no other pillows on either side of the bed. The resident's eyes were closed. The resident was not receiving care from staff at this time. On 11/26/12 at 12:00 p.m., the resident was observed in bed with her eyes closed. The resident was on her back and the pillows remained under each of her arms. There were no other pillows on either side of the bed. The resident's eyes were closed. LPN #2 entered the room at this time and administered medications to the resident through her feeding tube. On 11/26/12 at 1:02 p.m., the resident was observed in bed with her eyes closed. The resident was on her back and the pillows remained under each of her arms. There were no other pillows on either side of the bed. The resident's eyes were closed. The resident was not receiving care from staff at this time. On 11/26/12 at 4:30 p.m., the resident was observed in bed with her eyes closed. The resident was on her back and the pillows remained under each of her arms. There were no other pillows on either side of the bed. The resident's eyes were closed. The resident was not receiving care from staff at this time.			

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	The record for Resident #N was reviewed on 11/26/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, respirator dependence, anemia, morbid obesity, and convulsions. Review of the 11/2012 Physician Order Statement indicated there was an order written on 10/30/12 to apply Calmosetpine cream to the groin and buttock areas every shift. Review of the 11/20/12 Pressure Wound Skin Evaluation Reports indicated the resident had a stage II ulcer to the right buttock and another stage II (an ulcer with partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed) ulcer to the right superior buttock area. The resident's current care plans were reviewed. There was a care plan indicating the resident was admitted to the facility with area to her left buttock, right buttock, and right superior buttock and the resident was dependent on staff for bed mobility. The care plan was initiated on 11/6/12. Care plan interventions included for the resident to be turned and repositioned routinely. Another care plan was initiated on 11/7/12. This care plan indicated the resident was at risk for further skin breakdown related to			

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	impaired mobility, incontinence, and a diagnosis of diabetes. Care plan interventions included for staff to turn and reposition the resident at least every two hours When interviewed on 11/28/12 at 9:35 a.m., the Director of Nursing indicated the resident was to be turned and repositioned every two hours as per her plan of care. 3. During orientation tour on 11/25/12 at 7:10 p.m., Resident #M was observed in bed. The resident was lying on her back. The resident was not receiving any care from staff at this time. On 11/25/12 at 8:15 p.m., the resident was observed in bed. The resident was awake. The resident was not receiving care from staff at this time. On 11/26/12 at 7:45 a.m., the resident was observed in bed. The resident was lying on her back and was not receiving care from staff at this time. On 11/26/12 at 8:50 a.m., the resident was observed in bed. The resident was lying on her back and was not receiving care from staff at this time. On 11/26/12 at 9:15 a.m., the resident was observed in bed. The resident was lying			

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	on her back and was not receiving care from staff at this time. On 11/26/12 at 10:25 a.m., the resident was observed in bed. The resident was lying on her back and was not receiving care from staff at this time. On 11/26/12 at 11:15 a.m., the resident was observed in bed. The resident was lying on her back and was not receiving care from staff at this time. On 11/26/12 at 12:55 p.m., the resident was observed sitting in a Broda chair in the unit Dining Room. On 11/26/12 at 1:55 p.m., the resident was observed sitting in the Broda chair in her room. CNA #2 and LPN #3 entered the resident's room and transferred the resident from the chair into her bed using a Hoyer lift device. When the resident was lifted from the Broda chair there was no type of pressure relieving cushion on the seat of the chair. The record for Resident #M was reviewed on 11/27/12 at 1:35 p.m. The resident's diagnoses included, but were not limited to, multiple sclerosis, iron deficiency anemia, dementia, and osteopath. Review of the 11/2012 Physician Order			

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	Statement indicated there was an order to cleanse the coccyx wound with normal saline, apply Soloist (an ointment to treat wounds), a fluffed gauze, and cover the wound with dressing once a day and as needed. The 11/20/12 Pressure Wound Skin Evaluation Report indicated the resident had a Stage IV (a wound with full thickness tissue loss with exposed bone, tendon, or muscle) wound to the coccyx. The wound measured 0.7 cm x 0.6 cm x 0.4 cm. Review of the 11/20/12 Pressure Sore Risk Assessment indicated the resident was at risk for skin breakdown as the resident has decreased mobility, a diagnosis of multiple sclerosis, and a history of pressure ulcers and a recent weight loss. The resident's current care plans were reviewed. A care plan initiated on 1/13/12 indicated the resident had open areas to the coccyx, heel, and knee area. Care plan interventions included for staff to turn and reposition the resident routinely. The care plan was last updated with a goal date of 12/4/12. Another care plan initiated on 4/12/11 indicated the resident was at risk for further skin breakdown related to impaired skin			

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	integrity, requiring total care for bed mobility and having contractures. Care plan interventions included for the resident to have a pressure reducing cushion to the Broda chair. When interviewed on 11/28/12 at 9:35 a.m., the Director of Nursing indicated the resident's plan of care for repositioning and the use of a pressure reducing cushion to the Broda chair should have been followed. This federal tag relates to Complaint IN00114283. 3.1-40(a)(2)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision related to implementing interventions to prevent elopement when a resident was transferred off a secured nursing unit. The facility also failed to ensure all employees were inserviced on procedures implemented after an elopement for 1 of 1 residents reviewed for elopement risk in the sample of 14. This deficient practice had the potential to affect 26 of 26 residents residing on the secured unit. (Resident #B) Findings include: During orientation tour on 11/25/12 at 7;15 p.m., Resident #B was observed to be residing on the "Cottage" unit which was a secured unit. The record for Resident #B was reviewed on 11/26/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety state, and depressive disorder. The	F0323	**F323 FREE OF ACCIDENTS/HAZARDS/ SUPERVISION/DEVICES** The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents This tag is being disputed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · A new elopement risk assessment was completed for Resident B and she was moved into the cottage. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · The facility implemented a	12/28/2012

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	resident had been moved off of the Cottage unit on 11/8/12 to another unit in the facility that was not a secured unit. Review of the 9/11/12 "Elopement Risk Assessment" indicated the resident was independently mobile with either ambulation or in a wheelchair, the resident often requested to go home and or is searching for home, and the resident experiences increased confusion at certain times of the day. The above indicated the resident was an elopement risk. Review of the 11/8/12 Facility Incident indicated the resident was brought into the facility by visitor at approximately 8:20 p.m. The resident did not leave the facility property. The resident had no injuries noted and no overt signs of distress. A wanderguard was applied upon the resident's return into the building. An IDT note made on 11/9/12 indicated the team met to review the resident's exit seeking and the resident was to be moved to a room on the secured unit at this time. When interviewed on 11/26/12 at 3:30 p.m., the Assistant Director of Nursing indicated the DON had put a new plan in place. The Assistant Director of Nursing provided the written plan at this time.		plan for residents being discharged from the cottage to the general facility. All staff was inserviced on the protocol by 11/28/12 and monthly ongoing at the all staff meeting. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The facility implemented a plan for residents being discharged from the cottage to the general facility. All staff was inserviced on the protocol by 11/28/12 and monthly ongoing at the all staff meeting. · The Director of Nursing Services is responsible to monitor for facility compliance. · Elopement Risk Assessments will be completed for any residents being discharged from the cottage to the general facility and the protocol will be followed. · The Unit Manager/designee will ensure that the protocol is followed and the orders are in place prior to a resident being discharged from the cottage. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**	

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	The plan was titled "Plan for Resident being discharged from Cottage to general facility." The policy was as follows: "Each resident discharged from the Cottage to the general facility will be issued a Wanderguard prior to exiting the Cottage. Prior to discharge from the Cottage to the general facility each resident will have physician orders as outlined below. 1. May discharge from Cottage. 2. Apply wanderguard. Check wanderguard at least every shift for placement. Restorative to check wanderguard daily for function. 3. Every 15 minute where-a-bout checks will be provided for the first 24 hours. 4. Every 30 minute where-a-bout checks will be provided for the following 24 hours. 5. Every hour where-a -bout checks for the next 24 hours. Elopement Assessment will be completed by the IDT after 72 hour where-a-bout checks are completed to determine if use of wanderguard is yet indicated." When interviewed on 11/27/12 at 8:05 a.m., the Director of Nursing indicated she implemented the above protocol after Resident #B had been found outside of the facility on 11/8/12. The Director of Nursing indicated when she was informed		· Observations will be documented on the "Missing Resident/Elopement" CQI tools weekly x 4, then monthly thereafter for at least 6 months. · Data will be submitted to the CQI Committee for review and follow up. **If a 95% compliance is not achieved an action plan will be developed.** · **Noncompliance with facility procedures may result in disciplinary action.**	

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	of the resident being found outside that evening she spoke with the Charge Nurse and informed her that no residents are to be out of the Secured unit until she arrived the next morning. The Director of Nursing indicated she inserviced the IDT members on the above protocol as they were the only ones that are involved in the decision to move any residents off the secured unit and they were to be responsible to ensure the Physician order were written as above and transcribed onto the Medication Administration Record or the Treatment Administration Record. The Director of Nursing indicated other staff were not inserviced as the orders would be written for staff to follow. When interviewed on 11/26/12 at 3:20 p.m., the Cottage Unit Manager indicated the resident had resided on the secured unit for several months prior to her being moved off the unit on 11/8/12. The Cottage Unit Manager indicated the resident was moved in the morning of 11/8/12 and was found outside of the facility that evening. The Cottage Unit Manager indicated there was not a policy related to the transfer of resident's off the secured unit. When interviewed again on 11/26/12 at 4:00 p.m., the Cottage Unit Manager			

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	indicated the resident had not been attempting to propel herself around the unit and the resident did not physically exit seeking. The Cottage Unit Manager indicated in the past the resident had made statements about thinking she was a visitor and her son had dropped her off . The resident did not have a wanderguard on while on the secured unit. When interviewed on 11/26/12 at 4:25 p.m., the facility Administrator indicated he was informed of the resident being found outside of the facility on 11/8/12. The Administrator indicated staff informed at that time. The Administrator indicated the protocol was for residents to have a wanderguard applied when they are transferred off the secured unit. The Administrator indicated the resident did not have a wanderguard placed on before she was transferred off the secured unit as per protocol. The Administrator indicated the Director of Nursing put a plan into place at the time the resident was was found outside. When interviewed on 11/27/12 at 9:30 a.m., the Cottage Unit Manager indicated it was protocol for all residents to have a wanderguard applied prior to being moved off the unit and this was not done for Resident #B on 11/8/12.			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to medications not signed out on the Medication Administration Records and lack of documentation of funeral home arrangements for 1 of 3 closed records reviewed for complete and accurate documentation in the sample of 14. (Resident #G) Findings include: The closed record for Resident #G was reviewed on 11/26/12 at 11:30 a.m. The resident's diagnoses included, but were not limited to, renal failure, adult failure to thrive, esophageal reflux, and high blood pressure. The resident was	F0514	**F514 Clinical Records** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**	12/28/2012

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	admitted to the facility on 4/7/12 and discharged to the hospital on 5/9/12. The resident was re-admitted to the facility on 5/16/12 from an inpatient Hospice facility. The resident expired at the facility on 5/19/12. Review of the resident's Admission information face sheet indicated there was no Funeral Home listed. One of the resident's daughters was listed as a contact /POA (Power of Attorney) for the resident. Review of the 5/2012 Nurses' Notes indicated an entry was made on 5/19/12 at 2:25 a.m., documented the resident was restless, yelling out, and her respirations were labored. The entry also indicated the resident was given Morphine (a pain medication) and Ativan (a medication for anxiety). An entry made on 5/19/12 at 3:58 a.m., indicated the resident's respirations had ceased at 3:25 a.m., and an order was obtained to release the body to the funeral home. The entry also indicated a message was left for the family member to call the facility. An entry made on 5/19/12 at 6:56 a.m., indicated several messages were left for the daughter who was the resident's POA and the funeral home was to be notified when the family was notified. The next entry in the Nurses' Notes was made on		· There is no corrective action for Resident G as she no longer resides at the facility. Resident G's family was notified and she was released to the funeral home the family chose. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · Licensed nurses will be re-educated on physician's orders and MAR/TAR documentation requirements and use of PRN medications by the DNS/designee by 12/28/12. · The information on the resident face sheets will be reviewed/verified with the resident's responsibility party. · Upon admission/re-admission the IDT will review the resident's face sheet during clinical meeting to ensure pertinent information is available. · IDT will review the information on the resident's face sheet during care plan meetings and update as needed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur	

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VALPARAISO CARE AND REHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5/19/12 at 9:02 a.m. This entry indicated the funeral home was at the facility and the resident's body was released. There was no documentation of family member being contacted for the funeral home choice. Review of the 5/2012 Medication Administration Record indicated the Morphine and Ativan medications were not signed out as given on 5/19/12 at 2:25 a.m. The facility policy titled "Medication Administration" was reviewed on 11/28/12 at 10:30 a.m. The policy was provided by the Director of Nursing. There was no date on the policy. The Director of Nursing indicated the policy was current. The policy indicated Nurses administering medications were to sign out the medications given on the Medication Record. When interviewed on 11/28/12 at 10:30 a.m., the Director of Nursing indicated the above doses of Morphine and Ativan should have been signed on the Medication Administration Record at the time they were given. This federal tag relates to Complaint IN00112997.		· The IDT reviews the physician orders at the clinical meeting. · The Unit Managers/designee will audit the MAR/TAR's to ensure physician's orders are followed (Monday-Friday). DNS/designee will assign a license nurse on weekends to review the medication administration records to · ensure medications have been administered per physician orders. · The "Care Plan Checklist" will be utilized during care plan reviews ongoing. This review includes all the information on the resident face sheet including funeral home of choice and will be updated as indicated by the IDT. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · The Unit Managers will complete the "MAR/TAR" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter for at least 6 months. · Social Services will complete a "Care Plan Updating" CQI tool weekly x 4 weeks and monthly ongoing thereafter for at least 6 months. · Data will be submitted to the CQI Committee for review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	3.1-50(a)(1) 3.1-50(a)(2)		and follow up. If a 95% compliance is not achieved an action plan will be developed. · Noncompliance with facility procedures may result in re-education and or disciplinary action.	